

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

13713

1. PLACE OF DEATH

County St. Clair  
Township Dallas  
City Gerster (No. ....)

Registration District No. 1118  
Primary Registration District No. 6010

File No. 11  
Registered No. ....  
St. .... Ward

2. FULL NAME

Harold Eugene Perkins

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF  
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE 16 YEARS MONTHS 9 DAYS 27  
If LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work High School Student  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Gerster Mo  
(STATE OR COUNTRY) St. Clair Co

10. NAME OF FATHER J. Perkins

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Gerster  
(STATE OR COUNTRY) St. Clair Co

12. MAIDEN NAME OF MOTHER Martha Perkins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Gerster Mo  
(STATE OR COUNTRY) St. Clair Co

14. INFORMANT J. E. Perkins  
(Address) Gerster Mo

15. FILED ..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April-30-1926

17. I HEREBY CERTIFY, That I attended deceased from April-20-1926 to April-30-1926.  
that I last saw him alive on April-30-1926, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Typhoid Fever (duration) yrs. mos. 21 da.  
CONTRIBUTORY Peritonitis (SECONDARY) (duration) yrs. mos. 6 da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No  
WHAT TEST CONFIRMED DIAGNOSIS? Physical Examination  
(Signed) A. S. Johnston, M. D.  
5-1-1926 (Address) Wheatland Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wheatland Mo DATE OF BURIAL 19

20. UNDERTAKER Perkins ADDRESS

# Revised United States Standard Certificate of Death

(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework* or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report

"Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*), may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

**NOTE.**—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS  
BY PHYSICIAN.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Clair Registration District No. 1118 File No. 4  
Township Ballou Primary Registration District No. 6010 Registered No. \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. Harold Eugene Perkins St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 9 mos. 27 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (with the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1909-7-3

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
16 9 27 — — —

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work High School student  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) St. Clair Co. Mo.

**10. NAME OF FATHER**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Clair Co. Mo.  
(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Clair Co. Mo.  
(STATE OR COUNTRY)

**14. INFORMANT**

(Address) Perkins, Mo.

**15. FILED**

May 3, 1926

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 30 1926

I HEREBY CERTIFY That I attended deceased from Apr. 20 to Apr. 30, 1926, that I last saw him alive on Apr. 30, 1926, and that death occurred, on the date stated above, at 1 p.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Dysphoid fever

**CONTRIBUTOR (SECONDARY)**

Pneumonia (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 31 ds.

**18. WHERE WAS DISEASE CONTRAIVED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Typical examination

(Signed) A. J. Johnston, M. D.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

Mr. White DATE OF BURIAL May 2, 1926

**20. UNDERTAKER**

Bolivar, Mo ADDRESS \_\_\_\_\_

3. Information should be carefully supplied. AGF should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly ascribed. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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BY PHYSICIAN.

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